

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for an MRI.
- b. The request was received on August 15, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on December 16, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on December 17, 2002. The response from the insurance carrier was received in the Division on December 30, 2002. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated December 9, 2002 that...
“...The issue in dispute is reimbursement for a lumbar MRI performed on January 30, 2002... TWCC Rule 133.304(C) states that when issuing a denial, a carrier must (1) use a TWCC approved denial code; and (2) state in non-generic language the basis for the carrier’s denial. In this case, the carrier has not utilized a TWCC approved denial code. The sole ground for denial raised by the carrier is ‘T.’ As you know, the TWCC Treatment Guidelines were abolished by operation of law on January 1, 2002. On August 7, 2002, the TWCC issued advisory 2002-11 which states that denial code ‘T’ is no longer a valid denial code and cannot be used to reduce or deny payment by an insurance carrier for dates of service on or after January 1, 2002. Pursuant to TWCC Rule 133.307(j)(2), a carrier may not raise new grounds for denial at MDR, and an MDRO may not consider new grounds for denial raised by the carrier. Because the sole basis for the carrier’s denial is invalid, and because this service was performed, full reimbursement plus interest should be ordered in this case...”
2. Respondent: The respondent states in the correspondence dated December 30, 2002 that... “A review of the documentation indicates the Provider-Requestor seeks additional reimbursement for an MRI of the lumbosacral spine delivered to the Claimant on January 30, 2002. Unfortunately, the services for which the Requestor seeks reimbursement were not medically necessary, hence merit no reimbursement... The course of treatment undertaken in this instance is both premature and unreasonable. It runs contrary to the guidelines set forth in the Spine Treatment Guidelines. The Carrier is aware that the Spine Treatment Guidelines were abolished by statute effective January 1, 2002. Nevertheless, in the absence of replacement guidelines, the former guidelines continue to service as a useful barometer of the medical necessity (or lack thereof) of certain services...”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is January 30, 2002.
2. The Spine Treatment Guidelines were abolished on January 1, 2002; respondent denied the disputed services using a denial code of “T”. Since denial code “T” is an incorrect denial and respondent did not deny the service for any other code the disputed date of service will be reviewed according to the *1996 Medical Fee Guideline* and TWCC Rules.
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
01/30/02	72148-27-22	\$1,150.00	\$0.00	T	\$924.00 (31 slices PCS is \$168.00 + TCS is \$756.00)	MFG, R/N MGR (I)(A)(3-4) & (II)(C)(3) Advisory 2002-11 Rule 133.304(C)	See #2 above. Requestor has submitted the MRI report dated 1/30/02 supporting services were rendered per the MFG. Therefore, reimbursement in the amount of \$924.00 is recommended.
Totals		\$1,150.00	\$0.00				The Requestor is entitled to reimbursement in the amount of \$924.00 .

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$924.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 06th day of February 2003.

Marguerite Foster
 Medical Dispute Resolution Officer
 Medical Review Division

MF/mf